Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA SURGICAL CENTER WEST
4301 VISTA ROAD
PASADENA TX 77504

Respondent Name
AMERICAN CASUALTY CO OF READING PA

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-03-1040-01

MFDR Date Received
OCTOBER 14, 2002

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated November 8, 2002: "Vista Surgical Center West charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Surgical Center West is at a minimum of 70% of billed charges. This is supported by a managed care contract with 'Focus'…This managed care contract supports Vista Surgical Center West's argument that the usual and customary charges are fair and reasonable and **at the very minimum**, 70% of the usual and customary charges is fair and reasonable…the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for Ambulatory Surgical Centers medical services."

Requestor's Supplemental Position Summary dated October 22, 2013: "Vista requested a copy of the pre-authorization letter on several occasions but none was ever provided…Specifically, the attached physician's intake/posting sheet reflects that pre-authorization was obtained from the carrier on December 14, 2001 with pre-authorization number 121401777036."

Amount in Dispute: $6,566.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary in the response packet.

Response Submitted by: RSKCO

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 26, 2001	Outpatient Hospital Services	$**6,566.00**	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305 and133.308 sets out the procedures for resolving medical

necessity disputes.

2. Former 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
3. Former 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on October 14, 2002. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, the Division notified the requestor on October 23, 2002 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 910-V-Unnecessary treatment based on a peer review.
   - F-Reduction according to Fee Guideline.

Issues

Does a medical necessity issue exist in this dispute?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon medical necessity reason code "910-V."

The requestor states in the position summary that "pre-authorization was obtained from the carrier on December 14, 2001 with pre-authorization number 121401777036." The Division requested copies of the preauthorization report to support position that the disputed services were preauthorized. The requestor states that "Vista requested a copy of the pre-authorization letter on several occasions but none was ever provided."

The documentation submitted does not identify what services were preauthorized with preauthorization number 121401777036; therefore, the requestor's documentation does not support that the disputed services were preauthorized.

Former 28 Texas Administrative Code §133.305(a)(2) defines a medical fee dispute as "Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines). The dispute is resolved by the commission pursuant to commission rules, including §133.307 of this title (relating to Medical Dispute Resolution of a Medical Fee Dispute)."

28 Texas Administrative Code §133.305(b) requires that "If there is a medical necessity dispute for which there are medical fee components, the requestor shall file one request for medical dispute resolution to the carrier and simultaneously file a copy with the commission for monitoring of carrier compliance pursuant to §133.308 of this title. The medical necessity dispute will be resolved prior to deciding the medical fee dispute pursuant to §133.307 of this title."

Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.

The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that a medical necessity issue exists in this dispute. Furthermore, the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §§ 133.305 and 133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/04/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.